

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/21/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155132		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2011	
NAME OF PROVIDER OR SUPPLIER  DANVILLE REGIONAL REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN46122			
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F0000	<p>This visit was for a Recertification and State Licensure survey. This visit included the investigation of Complaint Number IN00086454.</p> <p>Complaint Number IN00086454: Unsubstantiated, allegation did not occur.</p> <p>Survey dates: February 21, 22, 23, 24, and 25, 2011</p> <p>Facility Number: 000057 Provider Number: 155132 AIM Number: 100266570</p> <p>Survey team: Janet Stanton, R.N.--Team Coordinator Rita Mullen, R.N. Michelle Hosteter, R.N.</p> <p>Census bed type: SNF--19 SNF/NF--70 Total--89</p> <p>Census payor type: Medicare--17 Medicaid--68 Other--4 Total--89</p> <p>Sample: 18</p>			F0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	These Federal deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.  Quality review completed on March 3, 2011 by Bev Faulkner, RN						

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F0279 SS=D	<p>Based on record review and interview, the facility failed to ensure a comprehensive care plan was developed by Speech Therapy, that included goals and interventions for compensatory strategies, for direct nursing staff to use in assisting a resident with swallowing difficulties to eat, for 1 of 15 residents reviewed for care plan development in a sample of 18. [Resident #29]</p> <p>Findings include:</p> <p>A Plan of Care for Nutritional Risk, dated 4/9/10 and last updated 12/21/10, indicated Resident #29 was at nutritional risk due to a gradual weight loss. Interventions included, but were not limited to, ground meats and assistance with meal set-up.</p> <p>A Physician's order, dated 12/21/10, indicated "ST (speech therapy) to eval (evaluate) for dysphagia (difficulty swallowing)."</p> <p>An ST note, dated 1/19/11, indicated "Reason for referral: Difficulty Chewing meats....Goals: Tolerate regular, ground meat without aspiration, will clean mouth and will tolerate diet changes....Trained pt (patient) &amp; staff on compensatory strategies." There were no indications of</p>			F0279	<p>Corrective Action: Speech Therapy (ST) provided an in-service to nursing staff regarding compensatory strategies. In addition, the careplan and resident assignment sheet was updated to reflect resident #29 current medical condition Other Residents Having the Potential to be Affected: ST will conduct an audit on all residents who have received ST within the past 60 days and are on current caseload to ensure that all information has been in-serviced to the appropriate staff regarding ST interventions. Assign-ment sheets and careplan reviewed and updated. Residents who have been assessed by ST, will be brought to the Daily Clinical Review (DCR). At that time, it will be determined if an in-service is necessary and a date will be established. Systematic changes: The Facility Rehab Coordinator (FRC) will receive copies of ST in-services that are provided to nursing. A copy of the in-services will be provided to the ETD to check for participation compliance. New orders will be brought to daily clinical triage meeting to monitor change in diets/altered diets in order to identify what educational needs are necessary. During this meeting, Medical Records or designee will update the assignment sheets and/or</p>		03/27/2011

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	<p>what compensatory strategies were to be used to assist Resident #29 during meals.</p> <p>The Nursing Assistant Assignment Worksheet received from the Assistant Director of Nursing, on 2/21/11 at 10:30 A.M., indicated Resident #29 was assist with meal set-up. Compensatory strategies were not on the assignment sheet nor were compensatory strategies on the plan of care.</p> <p>During an interview with L.P.N. #4 on 2/22/11 at 10:30 A.M., L.P.N. #4 indicated they did not know what the compensatory strategies were for Resident #29 during meals.</p> <p>During an interview with ST #5, on 2/22/11 at 11:20 A.M., she indicated the nurse and C.N.A. were instructed to cue the Resident while she was eating.</p> <p>3.1-35(b)(1)</p>			<p>careplan and an in-service will be scheduled as necessary. Monitoring: ST will observe new residents placed on compensatory strategies weekly x 4 weeks to ensure compliance, this will be ongoing. New orders will be monitored daily at the clinical triage meeting to determine if in-servicing has been completed, as well as, updating assignment sheets &amp; careplan(s). If a trend has been identified, a QA plan of action will be initiated, with weekly follow up until resolved. Any identified QA will be brought to the monthly QA on an ongoing basis or until the QA team determines otherwise.</p>			

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F0282 SS=D	<p>Based on record review and interview, the facility failed to follow a physician's order for a urinalysis test to determine the presence of an infection, for 1 of 15 residents reviewed for the following of physicians orders, in a sample of 18 residents reviewed. [Resident #29]</p> <p>Findings include:</p> <p>1. The clinical record of Resident #29 was reviewed on 2/21/11 at 1:45 P.M.</p> <p>Diagnoses for Resident #29 included, but were not limited to, constipation, dementia, depression, high blood pressure and anxiety.</p> <p>A Physician's order, dated 11/29/10, indicated "UA (urinalysis) C&amp;S (culture and sensitivity) for possible UTI (urinary tract infection)."</p> <p>A Nursing note, dated 11/29/10 at 9:30 P.M., indicated "...Suspect UTI. MD called &amp; ordered received for UA C&amp;S. I&amp;O (in and out) cath. Will continue to monitor &amp; encourage fluids."</p> <p>A Nursing note, dated 11/30/10 at 4:45 A.M., indicated "...Attempted I&amp;O cath for UA x 2 [without] results....Will attempt later." There were no further</p>		F0282	<p>Corrective Action: Due to multiple attempts to obtain the sample, the order to obtain UA CNS that was written on 11-29-10 was d/c'd per physician. No negative outcome was identified. Potential to be affected: A 100% audit has been completed of all lab orders to ensure there are no missed labs or lab results. Resident #29 labs were included in this audit to ensure no additional labs were missed per physician order. Systematic Changes: An In-service was provided to licensed nursing staff on ways to obtain a UA and what procedures need to be taken if a UA cannot be obtained. An in-service was provided to nurse leadership regarding auditing of labs during monthly change-over to ensure labs are not missed. All lab orders will be reviewed daily and checked off when the sample/draw has been obtained. If the sample/draw cannot be obtained after 3 attempts or within a 24 hour period, the physician will be notified for order clarification. This will be ongoing. Monitoring: All lab orders will be reviewed during DCR 5x/week and at the end of the month during monthly change-over to ensure no labs are outstanding. This will be ongoing. Results of the audit will be brought to monthly QA ongoing unless otherwise noted by the QA members.</p>		03/27/2011	

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	nursing notes regarding the UA C&S. A Lab report was not found.  During an interview with the Assistant Director of Nursing (A.D.O.N.), on 2/22/11 at 1:15 P.M., she indicated the UA C&S was not done, lab results could not be found.  3.1-35(g)(2)						

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F0309 SS=D	<p>Based on record review and interview, the facility failed to monitor and treat resident's, without bowel movements (BM) for three days or more. This impacted 2 of 9 residents review for bowel movements in a sample of 18. (Residents #29 and 92)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #29 was reviewed on 2/21/11 at 1:45 P.M.</p> <p>Diagnoses for Resident #29 included, but were not limited to, constipation, dementia, depression, high blood pressure and anxiety.</p> <p>A Plan of care for Alteration in Bowel Elimination, dated 4/14/10 and up-dated 12/17/11, indicated Resident #29 was at risk due to a history of constipation and dementia, with a Goal of: "Will have BM q [every] 3 days." Interventions included, but were not limited to, "Monitor bowel elimination using Care Tracker."</p> <p>A Physician's order, dated 7/19/10, indicated "Bisacodyl 10 mg (milligrams) suppository, insert 1 suppository rectally once a day as needed for constipation."</p>			F0309	<p>Corrective Action: Resident #29 &amp; #92 bowel regimen has been reviewed for bowel activity to ensure that no more than 3 days/9 consecutive shifts have not gone by without a bowel movement. The physician has been notified to review current medication regimes and/or possible bowel regimen changes. No negative outcome identified. Potential to be Affected: A one time record review was completed and no residents were identified as being at risk. however, the facility will continue to provide dietary and nursing interventions as indicated. Bowel records were pulled from the Care Tracker and all residents were reviewed for no BM &gt; 3 days/9 consecutive shifts. Dietary and nursing interventions reviewed to ensure appropriate interventions in place. Any resident identified as a concern will be discussed by the IDT members for potential recommendations and the physician will be notified as necessary. An in-service will be provided for all nursing staff on the bowel and bladder protocol/policy, which includes documentation of bowel results. Systematic Changes: An in-service will be conducted for licensed nurses regarding bowel assessments, gathering bowel regimen information from the resident while out of the building</p>		03/27/2011

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	<p>A Physician's order, dated 7/19/10, indicated "Milk of Magnesia (MOM) supp., Give 30 ml (milliliters) orally every other day PRN (as needed) for constipation."</p> <p>A review of the Care Tracker for bowel movements for the month of November 2010 indicated the following for Resident #29:</p> <p>11/4/10 through 11/12/10, the Care Tracker indicated "No" for BM's for 9 days.</p> <p>11/25/10 through 11/29/10, the Care Tracker indicated "No" for BM's for 4 days.</p> <p>A review of the Medication Administration Record (MAR), dated for the month of November 2010, indicated Resident #29 received MOM 30 ml on 11/12/10 at 6:00 P.M.</p> <p>A review of the Care Tracker for bowel movements for the month of December 2010 indicated "No" for BM's for 4 days, 12/25/10 though 12/28/10.</p> <p>A review of the MAR, dated for the month of December 2010, indicated Resident #29 was not treated for</p>				<p>and from those residents who toilet themselves to ensure that bowel movements are recorded on those who are not assisted by staff. Unit Managers will be responsible for pulling daily bowel reports from Care Tracker and bring to the clinical triage meeting 5 days/week. Any resident identified as not having a bowel movement for 9 consecutive shifts will be assessed, physician notified and physician bowel protocol initiated as indicated. Monitoring: The bowel regimen will be tracked by the licensed nurse every shift. The Unit Manager will pull off the daily bm activity report from the Care Tracker to identify if any resident(s) have not had a bm for 3 days/9 consecutive shifts. Bowel protocol will be implemented for any identified residents. This proces will be followed up to 72 hours each occurrence and ongoing. A QA will be initiated if any trends are identified and monitored x 4 weeks and brought to monthly QA until resolved and/or until the QA team determines otherwise. If trends identified, re-eduction will be provided and disciplinary action followed as necessary.</p>		

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	<p>constipation.</p> <p>A review of the Care Tracker for bowel movements for the month of January 2011 indicated "No" for BM's for 4 days, 1/27/11 though 1/30/11.</p> <p>A review of the MAR, dated for the month of January 2011, indicated Resident #29 was not treated for constipation.</p> <p>A review of the Nursing notes, dated November 2010 through January 2011, did not indicate an abdominal assessment was performed on Resident #29.</p> <p>2. The clinical record of Resident #92 was reviewed on 2/23/11 at 2:15 P.M.</p> <p>Diagnoses for Resident #92 included, but were not limited to, failure to thrive, Osteoarthritis, chronic constipation and traumatic brain injury as a child.</p> <p>A Physician's order, dated 2/27/09, indicated "Milk of Magnesia (MOM) supp., Give 30 ml (milliliters) orally every other day PRN (as needed) for constipation."</p> <p>A Physician's order, dated 6/22/10, indicated "Bisacodyl 10 mg (milligrams)</p>						

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	<p>suppository, insert 1 suppository rectally once a day as needed for constipation."</p> <p>A review of the Care Tracker for bowel movements for the month of November 2010 indicated "No" for BM's on the following days:</p> <p>11/1/10 through 11/7/10, the Care Tracker indicated no BM for 7 days.</p> <p>11/28/10 through 12/5/10, the Care Tracker indicated no BM for 8 days.</p> <p>A review of the MAR, dated for the month of November 2010, indicated Resident #92 was not treated for constipation.</p> <p>A review of the Care Tracker for bowel movements for the month of December 2010 indicated "No" for BM's on the following days:</p> <p>12/10/10 through 12/13/10, the Care Tracker indicated no BM for 4 days.</p> <p>12/18/10 through 12/24/10, the Care Tracker indicated no BM for 7 days.</p> <p>A review of the MAR, dated for the month of December 2010, indicated Resident #92 was not treated for</p>						

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	<p>constipation.</p> <p>A review of the Care Tracker for bowel movements for the month January 2011 indicated no BM's on the following days:</p> <p>1/25/11 though 1/29/11, the Care Tracker indicated no BM for 6 days.</p> <p>A review of the MAR, dated for the month of January 2011, indicated Resident #92 was not treated for constipation.</p> <p>A review of the Nursing notes, dated November 2010 through January 2011, did not indicate an abdominal assessment was performed on Resident #92.</p> <p>During an interview with Assistant Director of Nursing, on 2/22/11 at 1:45 P.M., she indicated that after 9 - eight hour works shifts (72 hours), if the resident is without a BM, the resident should get something for constipation.</p> <p>3.1-37(a)</p>						

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F0314 SS=G	<p>Based on observation, interview and record review, the facility failed to proactively implement effective and timely interventions to prevent a friction/shear wound from developing into a Stage 4 pressure ulcer, [Resident #83]; and failed to ensure a liquid protein nutritional supplement ordered to enhance the healing of a pressure sore was administered, [Resident #68]. This impacted 2 of 4 residents reviewed with pressure ulcers in a sample of 18 residents.</p> <p>Findings include:</p> <p>1. In an interview during the initial tour on 2/21/11 at 10:55 A.M., the A.D.O.N. [Assistant Director of Nursing] indicated Resident #83 had a Stage 4 pressure sore on the coccyx, which was acquired in-house. The resident currently had a "Roho" pressure-relieving cushion for his wheelchair, and was transferred in and out of bed with a mechanical lift.</p> <p>The clinical record for Resident #83 was reviewed on 2/22/11 at 9:00 A.M. Diagnoses included, but were not limited to, C.V.A. [stroke] with left arm weakness, depression, and incontinence [loss of control] of bowel and bladder. The resident was hospitalized on 11/29/10</p>		F0314	<p>Danville Regional Rehabilitation Center is respectfully requesting an Informal Dispute Resolution for the scope and severity of the following citation (314) to lessen the terms of the scope and severity. Corrective Action: Resident #68 assessed, physician notified and plan of care updated as indicated. Resident #83 re-assessed and continues to have interventions in place for prevention. Potential to be affected: A 100% skin sweep will be completed on all in-house residents. Physician and families will be notified of changes, current and new orders/interventions will be reviewed and care planned. A weekly skin review will occur with IDT members, ongoing. An in-service has been completed for all nursing regarding skin care, assessments, preventative measures and notification process. Systematic Changes: Facility will conduct weekly skin assessments per policy and procedure utilizing the weekly systems review audit form. Any resident identified at risk or change of condition by the IDT members, the physician will be notified to ensure appropriate interventions are in place. Monitoring: The weekly skin systems review will be monitored at the monthly QA for review and update as indicated. Any trends identified, physician will be</p>		03/27/2011	

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	<p>and returned to the facility on 12/1/10.</p> <p>A document titled "Admission Skin Assessment" indicated, by a pictograph, that the resident had a pressure sore measuring 0.4 cm. [centimeters] by 3 cm., and located on the top posterior portion of the left inner thigh, below the buttock. Another area was identified at the top posterior portion of the right inner thigh, below the buttock, measuring 0.3 cm. by 2 cm. No other areas of pressure sores or skin breakdown were identified on the form.</p> <p>A "Braden Risk Assessment Scale" form, dated 12/1/10, indicated the resident was at "... moderate for risk of skin breakdown...." upon return from hospital. On 12/15/10, he was assessed to be at "... high risk for skin breakdown....," and on 12/19/10, 12/22/10, and 1/12/11, he was assessed to be at "...moderate risk for skin breakdown...."</p> <p>A "Physician Notification" form, dated 12/14/10 at 2:50 P.M., indicated the resident had "... new areas [pressure sores] on buttock and coccyx," with a date and time of onset of symptoms 12/14/10.</p> <p>The "Wound Evaluation Progress Notes" from the facility's Wound physician</p>				<p>notified with careplans and interventions updated as needed.</p>		

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	<p>specialist, indicated the following:</p> <p>12/15/10--the resident had "two areas on the right gluteal and left buttock... friction wounds." An area on the coccyx was not identified.</p> <p>12/22/10--"... still has areas on right and left buttock, ...friction...."</p> <p>12/28/10--"... friction wound on coccyx measuring 6.8 x 4.0 and wound base 100% red."</p> <p>1/5/11--the note indicated the resident had "friction wound on LT [left] coccyx measuring 2.1 x 0.8 cm, 10 % wound base red, 90% yellow, and no black. Right buttock measuring 2.4 x 1.1, 10 % of wound base red, 90% yellow and no black. On mid line coccyx 1.2 x 0.4, 60% wound base red, 40% yellow and no black."</p> <p>1/12/11-- the note indicated friction wounds to these areas: R [right] buttock 1.8 x 1.2 x &lt; 0.1, with 100 % wound base red . LT coccyx 0.6 x 0.3 and 100% wound base red, and mid line coccyx 1.8 x 0.7 x &lt; 0.1 with 100% wound base red." All areas had a minimal amount of serous (clear fluid) drainage.</p>						

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	1/19/11--"... friction/shear wound on coccyx 5.5 x 4.2.... Hoyer [mechanical] lift only, no slide board...."  1/26/11--"... friction/shear wound on coccyx 7.2 x 3.7 x 0.2."  2/2/11--"... friction/press [pressure], Stage II 5.6 x 4.5 moderate amount of serous drainage and 70% wound base red and 30 % yellow."  2/9/11--"... friction wound sacral/coccyx 7.5 x 4.5 x 1.0.... Pt. [patient] must be on left/right side, not on back. Pt. continues to move into position onto back. In bed only for sleep...."  2/16/11--"... coccyx wound 5.8 x 3 x 0.8, 70 % red wound base and 30% yellow."  One Care Plan entry, originally dated 12/14/10 with a most recent revision date of 2/16/11, addressed a problem of " SKIN INTEGRITY ASSESSMENT: PREVENTION AND TREATMENT PLAN." In the section for "Skin Protection," with a start date of 12/14/10, the following interventions checked: "use assistive devices to reduce friction and facilitate resident movement such as: turning sheets, overbed trapeze, resident lift...." In the section for "Manage						

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	<p>Friction and Shear," no interventions were checked. The resident was observed to have a trapeze over his bed.</p> <p>On 2/8/11 an intervention was added for a "... Stat 3 air mattress to aid in wound healing...."</p> <p>On 2/23/11 at 11:45 A.M., the resident was observed while the Wound Care specialist physician evaluated his open areas. The physician indicated the area was a friction wound measuring 3.5 x 3.4 x 2.7, noting a color of 10 % red and 96% black superficial with minimal serous exudate. The coccyx wound was observed to have dark gray tissue, and the physician was able to place half of his index finger inside the wound while assessing. The surrounding wound tissue had areas of red and yellow and the outer rim of wound was pink in color. The wound was also noted to have a mild odor. The wound dressing the physician removed from the area was noted to be partially saturated with a light, yellow fluid.</p> <p>In an interview on 2/23/11 at 3 P.M., the Director of Nursing indicated the resident had previously used the facility's standard pressure-reducing mattress prior to the order for the Stat 3 specialty low air loss mattress on 2/8/11.</p>						

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F0314 SS=G	<p>2. In an interview during the initial orientation tour on 2/21/11 at 10:55 A.M., R.N. #1 indicated Resident #68 had pressure sore open areas of the sacrum and both ischial prominences.</p> <p>In an interview on 2/23/11 at 11:15 A.M., L.P.N. #2, the facility Wound Nurse, indicated Resident #68 was admitted about 1 year ago with multiple massive open areas of both heels and legs, the sacrum, and bilateral ischium. She indicated the resident had been followed weekly since admission by the facility wound care physician/specialist, and that the areas on the heels and legs were now healed. The sacral and ischial areas, while still open, were significantly reduced in size. L.P.N. #2 also indicated part of the difficulty in getting the areas healed was due to the long time periods the resident had to sit during his dialysis.</p> <p>The clinical record for Resident #68 was reviewed on 2/22/11 at 10:30 A.M. Diagnoses included, but were not limited to, diabetes, paraplegia, end-stage renal disease with hemodialysis, and pressure ulcers.</p> <p>A "Wound Evaluation Progress Note" from the facility Wound physician specialist, dated 12/1/10, indicated the</p>			F0314	<p>Danville Regional Rehabilitation Center is respectfully requesting an Informal Dispute Resolution for the scope and severity of the following citation (314) to lessen the terms of the scope and severity. Corrective Action: Resident #68 assessed, physician notified and plan of care updated as indicated. Resident #83 re-assessed and continues to have interventions in place for prevention. Potential to be affected: A 100% skin sweep will be completed on all in-house residents. Physician and families will be notified of changes, current and new orders/interventions will be reviewed and care planned. A weekly skin review will occur with IDT members, ongoing. An in-service has been completed for all nursing regarding skin care, assessments, preventative measures and notification process. Systematic Changes: Facility will conduct weekly skin assessments per policy and procedure utilizing the weekly systems review audit form. Any resident identified at risk or change of condition by the IDT members, the physician will be notified to ensure appropriate interventions are in place. Monitoring: The weekly skin systems review will be monitored at the monthly QA for review and update as indicated. Any trends identified, physician will be</p>		03/27/2011

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	<p>resident had the following areas: Sacrum--3.8 by 4.3 by 1.2 cm. [centimeters]; right ischium--4.3 by 3.0 by 1.8 cm.; and left ischium--5.4 by 2.3 by 1.0 cm.</p> <p>A "Wound Evaluation Progress Note" on 2/16/11 indicated the following measurements: Sacrum--4.3 by 3.4 by 1.7 cm.; right ischium--5 by 2.8 by 0.6 cm.; and left ischium--8 by 3.6 by 2 cm.. The note indicated "Discussed with pt. [patient] need to minimize time sitting up...."</p> <p>The resident's wounds were observed during an evaluation and dressing change by the Wound physician and facility Wound nurse on 2/23/11 at 11:15 A.M. The physician pointed out the healed areas on the resident's heels and legs. The sacrum and right ischium areas were observed to have a clean, beefy red appearance. The Wound physician indicated the left ischial area had just recently developed a small area of necrosis, which he would probably have to debride.</p> <p>The February, 2011 physician order recap [recapitulation] list included an order, dated 10/21/10, for "Prostat" [a liquid protein supplement], 30 ml. [milliliters] twice a day for "wound healing." On</p>				notified with careplans and interventions updated as needed.		

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	<p>12/8/10, the physician increased the dosage of Prostat to 30 ml. three times a day.</p> <p>The January 2011 M.A.R. [Medication Administration Record] listed the order as "Prostat 30 ml. orally 3 times a day to aid in wound healing." The administration times, however, were listed at 12:00 P.M. and 8:00 P.M. There was no additional listing for a third administration of the supplement.</p> <p>The M.A.R. also indicated the resident received the Prostat twice a day from 1/1 through 1/13/11, then only at 12:00 P.M. from 1/14 through 1/21/11. The 8:00 P.M. dose was circled for these days, indicating the Prostat was not given. The doses at 12:00 P.M. and 8:00 P.M. from 1/22 through 1/31/11 were circled, indicating both doses were not given. The "Nurse's Medication Notes" on the reverse side of the M.A.R. listed 14 entries indicating the Prostat "Beneprotein" supplement was "NA" [not available].</p> <p>The February 2011 M.A.R. had all entries from 2/1 through 2/23/11 circled as "not given," with "Nurse's Medication Notes" on the reverse side indicating the Prostat was not available. Notes on 2/4, 2/16, and 2/20/11 also indicated "[name of</p>						

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	<p>pharmacy] notified," with no subsequent notes to indicate the results of the notification.</p> <p>In an interview on 2/24/11 at 1:05 P.M., L.P.N. #3 indicated she usually worked on another unit, and had only been on the resident's unit yesterday (2/23) and today. She indicated she became aware that the Prostat was not available and called the pharmacy. A pharmacy staff person told her that the Prostat came in 4 different formulations, and they would need a further order from the physician on which one he wanted. L.P.N. #3 indicated she then called the physician and got a clarification order. She had no information related to why this had not been done previously.</p> <p>In an interview on 2/24/11 at 3:10 P.M., the Director of Nurses indicated she became aware of the problem with the Prostat orders just recently.</p> <p>3.1-40(a)(2)</p>						

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F0333 SS=D	<p>Based on interview and record review, the facility failed to ensure that a wound-healing protein supplement, prescribed by the physician, was given to 1 of 1 resident reviewed who was receiving the supplement, in a survey sample of 18 residents. The resident failed to received 59 doses in January, and 69 doses in February. [Resident #68]</p> <p>Findings include:</p> <p>1. In an interview on 2/23/11 at 11:15 A.M., L.P.N. #2, the facility Wound Nurse, indicated Resident #68 was admitted about 1 year ago with multiple massive open areas of both heels and legs, the sacrum, and bilateral ischium. She indicated the resident had been followed weekly since admission by the facility wound care physician/specialist, and that the areas on the heels and legs were now healed. The sacral and ischial areas, while still open, were significantly reduced in size.</p> <p>The clinical record for Resident #68 was reviewed on 2/22/11 at 10:30 A.M. Diagnoses included, but were not limited to, diabetes, paraplegia, end-stage renal disease with hemodialysis, and pressure ulcers.</p>		F0333	<p>Corrective Actions: The physician was notified and the resident was placed on benefiber. The wound physician assessed the resident and provided an updated progress note. Careplan has been updated. Potential to be Affected: An 100% audit of all residents MAR's have been completed to identify if other residents were affected. All nurses who participate in the monthly change-over will be re-educated on the month end change-over process. An in-service has been provided to the licensed nurses on the policy regarding unavailable medications and what to do if the medication is not available. The 24-hour status report sheet will be utilized to communicate to each shift what medications are outstanding. The Unit Manger will review the 24 hour status report sheet daily and follow up as necessary. This will be ongoing. Systematic Changes: Medical Records/Unit Manager(s) will review resident MAR's daily to ensure all of the orders are complete and/or no medications are outstanding. In addition, during the month end change-over process, we will incorporate a monthly audit that will be done on the "completed" MAR's to ensure compliance. This will be ongoing. Discrepancies will be brought to DCR for review and addressed as</p>		03/27/2011	

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	<p>The February, 2011 physician order recap [recapitulation] list included an order, dated 10/21/10, for "Prostat" [a liquid protein supplement], 30 ml. [milliliters] twice a day for "wound healing." On 12/8/10, the physician increased the dosage of Prostat to 30 ml. three times a day.</p> <p>The January 2011 M.A.R. [Medication Administration Record] listed the order as "Prostat 30 ml. orally 3 times a day to aid in wound healing." The administration times, however, were listed at 12:00 P.M. and 8:00 P.M. There was no additional listing for a third administration of the supplement.</p> <p>The M.A.R. also indicated the resident received the Prostat twice a day from 1/1 through 1/13/11, then only at 12:00 P.M. from 1/14 through 1/21/11. The 8:00 P.M. dose was circled for these days, indicating the Prostat was not given. The doses at 12:00 P.M. and 8:00 P.M. from 1/22 through 1/31/11 were circled, indicating both doses were not given. The "Nurse's Medication Notes" on the reverse side of the M.A.R. listed 14 entries indicating the Prostat "Beneprotein" supplement was "NA" [not available].</p> <p>The February 2011 M.A.R. had all entries</p>				<p>needed. Any identified trends will have a QA generated and followed up on weekly for no less than 4 weeks with the results of the audit taken to QA monthly x 3 months then quarterly thereafter unless otherwise determined by the QA team. Monitoring: Unit Manager's/nurse supervisor will check MAR's daily with all orders to ensure medications are received, available and administered per physician order. Daily audits will be provided x 4 weeks, then no less than 2x/week x 4 weeks, then weekly x 4 weeks. Information will be brought to monthly QA for monitoring to ensure compliance. QA members will determine monitoring outcomes during monthly QA, ongoing unless otherwise determined by the QA members.</p>		

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	<p>from 2/1 through 2/23/11 circled as "not given," with "Nurse's Medication Notes" on the reverse side indicating the Prostat was not available. Notes on 2/4, 2/16, and 2/20/11 also indicated "[name of pharmacy] notified," with no subsequent notes to indicate the results of the notification.</p> <p>In an interview on 2/24/11 at 1:05 P.M., L.P.N. #3 indicated she usually worked on another unit, and had only been on the resident's unit yesterday (2/23) and today. She indicated she became aware that the Prostat was not available and called the pharmacy. A pharmacy staff person told her that the Prostat came in 4 different formulations, and they would need a further order from the physician on which one he wanted. L.P.N. #3 indicated she then called the physician and got a clarification order. She had no information related to why this had not been done previously.</p> <p>In an interview on 2/24/11 at 3:10 P.M., the Director of Nurses indicated she became aware of the problem with the Prostat orders just recently.</p> <p>3.1-48(c)(2)</p>						

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F0514 SS=D	<p>Based on record review and interview, the facility failed to maintain accurate records of bowel movements for 1 of 1 resident, or document assessments for a resident with chest congestion that required a chest X-ray. This impacted 2 of 18 residents reviewed for complete and accurate clinical records in a sample of 18. (Residents #68 and 121)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #121 was reviewed on 2/25/11 at 10:00 A.M.</p> <p>Diagnoses for Resident #121 included, but were not limited to, Alzheimer's disease, chronic obstructive pulmonary disease, diabetes and heart block with pacemaker. The resident had been in the hospital with pneumonia.</p> <p>A cardiovascular/circulatory plan of care, dated 1/11/11, indicated Resident #121 was at risk due to CAD (coronary artery disease)</p> <p>A Nursing note, dated 1/13/11 at 2:00 A.M., indicated "Pt (patient) resting quietly in bed [without] c/o (complaints of) pain or SOB (shortness of breath). VSs (vital signs) 131/58. 66, 24, 98.6 92% RA (room air). Lungs sound exhibit</p>			F0514	<p>Corrective Actions: Resident 121 was discharged from the facility during the time of the survey. Resident 68 bowel activity regimen was reviewed in DCR, dialysis center notified to discuss bowel communication, documentation completed as appropriate, careplan reviewed, no interventions were necessary. Potential to be Affected: Unit Managers will be reviewing pertinent charting daily in comparison with the 24 hour status report sheet. Charting will be initiated for identified residents based upon current clinical condition(s) and placed on the 24 hour status report sheet for further monitoring and follow up. (No other residents were identified to be affected). Systematic Changes: An in-service has been completed for licensed nurses regarding change in condition that includes resident assessments. Unit Manager's will pull bowel activity report from Care Tracker daily to monitor bowel activity per policy. Dialysis Center notified of bowel communication and has agreed to communicate bowel activity on dialysis run log. Change of condition will be a part of pertinent charting x 72 hours and reviewed in DCR 5 days/week. Unit Manager's/nursing supervisor will review pertinent charting daily (ongoing) to ensure</p>		03/27/2011

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	<p>wheezes in [upper], diminished in [lower]. Congestion continues...ATB (antibiotic) cont (continues)..."</p> <p>A Nursing note, dated 1/13/11 at 9:30 A.M., indicated "167/88 - 118 - 18 99.2. New orders CBC (complete blood count) in a.m. CXR (chest x-ray) called today....Congested lungs sounds [with] exp. wheeze, non-prod cough. Skin warm to touch, face flushed, denies pain denies SOB duo nebs (a respiratory medication) PRN (as needed) given."</p> <p>A Nursing note, dated 1/13/11 at 9:40 A.M., indicated "[decreased] HR (heart rate) during neb tx (treatment) 54-60/min. assist to side of bed. HR [increased] 92. retake temp 97.3. [right] lower lobes [with] rales wheezing...cough dry non-prod..."</p> <p>A Nursing note, dated 1/13/11 at 10:30 A.M., indicated "CXR done."</p> <p>A late entry Nursing note on 1/14/11(no time indicated) written for 1/13/11 at 12:30 P.M., indicated "To dining room for lunch....return to bed..." No documented assessment of the resident's lung status.</p> <p>A late entry Nursing note on 1/14/11 (no time indicated) written for 1/13/11 at 1:30</p>				<p>compliance.Monitoring: Residents with significant change, change in condition and new orders will be reviewed at daily clinical triage 5x/week and brought to DCR as necessary to review documentation, assessments and care plan. Any trends identified will immediately be placed on a QA for evaluation and correction. Any QA identified will be documented on weekly for no less than 4 weeks and brought to monthly QA on an ongoing basis unless otherwise noted by the QA team.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/21/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155132		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2011	
NAME OF PROVIDER OR SUPPLIER  DANVILLE REGIONAL REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN46122			
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	<p>P.M., indicated "Resting quietly [with] family @ bedside, dozing...afebrile (no fever) @ 98.2. Denies needs..." No documentation of the resident's lung status. The next nursing note was dated 1/14/11 at 3:00 A.M.</p> <p>A Nursing note, dated 1/14/11 at 3:00 A.M., indicated "In bed resting; alert to name &amp; place, skin W&amp;D (warm &amp; dry) to touch...O2 (oxygen) via n/c (nasal canula) continues @ 2 liters [with] Spg (sic) = 92%." No documentation of the resident's lung status and no documentation of when the resident was started on oxygen.</p> <p>During an interview with the Director of Nursing, on 1/25/11 at 11:00 A.M., she indicated the charting has some gray areas and could be better.</p>						

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F0514 SS=D	<p>2. In an interview during the initial orientation tour on 2/21/11 at 10:55 A.M., L.P.N. #1 indicated Resident #68 received hemodialysis at an outside agency three times a week--on Monday, Wednesday, and Friday.</p> <p>The clinical record for Resident #68 was reviewed on 2/22/11 at 10:30 A.M. Diagnoses included, but were not limited to, diabetes, paraplegia, end-stage renal disease with hemodialysis, pressure ulcers, and constipation.</p> <p>One Care Plan entry, originally dated 8/6/10, addressed a problem of "Alteration in Bowel Elimination-Incontinence," with a "Goal" of "Will have B.M. [bowel movement] every 3 days." Interventions included, but were not limited to, "Monitor bowel elimination using CareTracker [the facility's computer tracking system]."</p> <p>A copy of the CareTracker "Bowel and Bladder Chart Detail Report," specific for B.M.s, was provided for 11/1/10 through 2/22/11.</p> <p>The report indicated the resident had "No" bowel movement for the following days:</p> <p>11/2/10, 10:21 P.M. through 11/16/10,</p>			F0514	<p>Corrective Actions: Resident 121 was discharged from the facility during the time of the survey. Resident 68 bowel activity regimen was reviewed in DCR, dialysis center notified to discuss bowel communication, documentation completed as appropriate, careplan reviewed, no interventions were necessary. Potential to be Affected: Unit Managers will be reviewing pertinent charting daily in comparison with the 24 hour status report sheet. Charting will be initiated for identified residents based upon current clinical condition(s) and placed on the 24 hour status report sheet for further monitoring and follow up. (No other residents were identified to be affected). Systematic Changes: An in-service has been completed for licensed nurses regarding change in condition that includes resident assessments. Unit Manager's will pull bowel activity report from Care Tracker daily to monitor bowel activity per policy. Dialysis Center notified of bowel communication and has agreed to communicate bowel activity on dialysis run log. Change of condition will be a part of pertinent charting x 72 hours and reviewed in DCR 5 days/week. Unit Manager's/nursing supervisor will review pertinent charting daily (ongoing) to ensure</p>		03/27/2011

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	<p>5:59 A.M. 12/11/10, 3:21 A.M. through 12/15/10, 1:58 P.M. 12/16/10, 12:26 A.M. through 12/22/10, 8:43 A.M. 1/5/11, 10:03 P.M. through 1/14/11, 6:05 A.M. 1/23/11, 4:15 A.M. through 1/26/11, 2:23 P.M. 2/14/11, 2:22 P.M. through 2/19/11, 10:23 P.M.</p> <p>There was no documentation that the resident had experienced episodes of constipation during these time frames.</p> <p>In an interview on 2/24/11 at 3:05 P.M., the Director of Nurses indicated the resident may have had a bowel movement when he was at dialysis, and that she had been working with that agency to get reports on any elimination while there.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>			<p>compliance. Monitoring: Residents with significant change, change in condition and new orders will be reviewed at daily clinical triage 5x/week and brought to DCR as necessary to review documentation, assessments and care plan. Any trends identified will immediately be placed on a QA for evaluation and correction. Any QA identified will be documented on weekly for no less than 4 weeks and brought to monthly QA on an ongoing basis unless otherwise noted by the QA team.</p>			